

FROM-II

Disability Certificate

(In cases of amputation or complete permanent paralysis of limbs and in cases of blindness)

(See Rule 4)

(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

Recent PP Size
Attested
Photograph
(Showing face
only) of the person
with disability

Certificate No.:

Date:

This is to certify that I have carefully examined

Shir/Smt./Kum.....

son/wife/daughter of Shri.....

Date of Birth..... Age.....Years, Male/Female.....
(DD/ MM / YY)

Registration No. Permanent Resident of House No.

Ward/Village/Street..... Post Office..... District.....

State.....

Whose photograph is affixed above, and am satisfied that:

(A) He/she is a case of:

*Locomotor Disability

*Blindness (Please tick as applicable)

(B) The diagnosis in his/her case is

(1) He/She has% (in figure percent (in words) permanent physical impairment/blindness in relation to his/her (part of body) as per guidelines (to be specified).

(2) The applicant has submitted the following document as proof of residence:

Nature of Document	Date of Issue	Details of authority issuing certificate

(Signature and Seal of Authorized Signatory of notified Medical Authority)

Signature/Thumb Impression of the person in whose favour disability certificate is issued

FORM-III
Disability Certificate
(In case of multiple disabilities)
(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)
(See Rule 4)

Recent PP size Attested Photograph(Showing Face only) of the person with disability

Certificate No. :

This is to certify that we have carefully examined
 Shri/Smt./Kum.....son/wife/daughter of
 Shri.....
 Date of Birth.....Age.....years, Male/Female.....
 (DD/MM/YY)

Registration No.Permanent Resident of House No..... Ward/Village/Street.....
 whose photograph is affixed above and are satisfied that:

(A) He/She is a case of **Multiple Disability**. His/Her extent of permanent physical impairment/disability has been evaluated as per guidelines (to be specified) for the disabilities ticked below and shown against the relevant disability in the table below:

S. No.	Disability	Affected Part of Body	Diagnosis	Permanent Physical Impairment/ Mental Disability(in%)
1	Locomotor Disability	@		
2	Low Vision	#		
3	Blindness	Both Eyes		
4	Hearing Impairment	£		
5	Mental Retardation	x		
6	Mental-illness	x		

(B) In the light of the above, his/her over all permanent physical impairment as per guidelines (to be specified), is as follows:

In figures:percent

In words :percent

2. This condition is progressive/non-progressive/likely to improve/not likely to improve.

3. Reassessment of disability is :

(i) not necessary,

Or

(ii) is recommended/afteryearmonths, and therefore this certificate shall be valid till(DD/MM/YY)

@ e.g. Left/Right/both arms/legs

e.g. Single eye/both eyes

£ e.g. Left/Right/both ears

4. The applicant has submitted the following document as proof of residence:

Nature of Document	Date of issue	Details of authority issuing certificate

5. Signature and seal of the Medical Authority

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Name and seal of Member

Name and seal of Member

Name and seal of the Chairperson

Signature/Thumb impression of the person in whose favour disability certificate is issued

FORM – IV

Disability Certificate

(In cases other than those mentioned in Forms II and III)

(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

(See Rule 4)

Recent PP size Attested
Photograph (Showing face only)
of the person with disability

Certificate No. :

Date:

This is to certify that I have carefully examined

Shri/Smt./Kum..... son/wife/daughter

of Shri

Date of Birth Age years, Male/Female.....
(DD) (MM) (YY)

Registration No. Permanent Resident of House No.

Ward/Village/Street Post Office District State

whose photograph is affixed above, and am satisfied that he/she is a case Disability. His/her extent of percentage physical impairment/disability has been evaluated as per guidelines (to be specified) and is shown against the relevant disability in the table below:

S. No	Disability	Affected Part of Body	Diagnosis	Permanent Physical Impairment/ Mental Disability (in %)
1	Locomotor Disability	@		
2	Low Vision	#		
3	Blindness	Both Eyes		
4	Hearing Impairment	£		
5	Mental Retardation	x		
6	Mental-illness	x		

(Please strike out the disabilities which are not applicable)

2. The above condition is progressive/non-progressive/likely to improve/not likely to improve.

3. Reassessment of disability is:

(i) not necessary,

Or

(ii) is recommended/after years months, and therefore this certificate shall be valid till

(DD) (MM) (YY)

@ e.g. Left/Right/both arms/legs

e.g. Single eye/both eyes

£ e.g. Left/Right/both ears

4. The applicant has submitted the following document as proof of residence:

Nature of Document	Date of Issue	Details of authority issuing certificate

Signature/Thumb
Impression of the
person in whose
favour disability
certificate is issued

(Authorised Signatory of notified Medical Authority)

(Name and Seal)

Countersigned

[(Countersignature and seal of the CMO/Medical
Superintendent/Head of Government Hospital in case the
certificate is issued by a medical authority who is not a government
servant (with seal)]**Note** : In case this certificate is issued by a medical authority who is not a government servant, it shall be valid only if countersigned by the Chief Medical Officer of the District.**Note** : The principal rules were published in the Gazette of India vide notification number S.O. 908(E), dated the 31st December, 1996.